HEALTH RESOURCES AND SERVICES ADMINISTRATION THIRD-PARTY REIMBURSEMENT

FINAL REPORT

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Submitted to:

Health Resources and Services Administration

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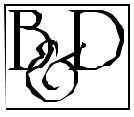

EXECUTIVE SUMMARY

1. BACKGROUND AND PURPOSE

As the lead Federal agency responsible for funding the delivery of ambulatory health services to America=s most vulnerable populations, the Health Resources and Services Administration (HRSA) has traditionally provided grant dollars directly to local entities or, through block and formula grants, to States and cities. Congress and the administration have anticipated that funding for providing health services to vulnerable populations would come from both the appropriations/ grant process and third-party insurance coverage programs, e.g., Medicaid, the Child Health Insurance Program (CHIP), Medicare, and some commercial insurance. The Federal policy position has been that third-party coverage should pay for the cost of health care for insurance program beneficiaries, thereby allowing Federal grant dollars to be focused on the health care of the uninsured and underinsured.

In the summer of 1999, HRSA contracted with Birch & Davis Associates, Inc., (B&D) to conduct a third-party reimbursement maximization technical assistance needs assessment of HRSA grantees. This called for determining whether grantee entities were in fact being reimbursed by insurance programs; if they were not, ascertaining the reasons why not; and developing strategies including training and technical assistance that would enhance the ability of HRSA grantees to maximize third-party revenues.

HRSA also formed a project steering committee composed of representatives of all of its grant programs:

- **$** Community and Migrant Health Centers (C/MHCs)
- **$** Rural Health (ORH)
- **$** Health Care for the Homeless (HCH)
- **$** AIDS-HIV Ryan White Title III
- **$** Maternal and Child Health subgrantees (MCH)
- **$** Healthy Start (HS)

The Steering Committee selected three States in which to carry out the project:

- **$** Michigan
- **$** Pennsylvania
- **$** Texas

Within each of these States, the Steering Committee designated nine grantees representing a cross-section of HRSA grant programs to be included in the project. These 27 entities with HRSA grants were eight community-based organizations, nine local public health departments, four local public hospitals, five teaching hospitals, and a statewide health care network.

2. APPROACH

The B&D Project Director assembled a group of consultants with extensive experience and expertise in the delivery of ambulatory care to vulnerable populations, HRSA grant programs, financial management, Medicaid and other third-party reimbursement, and managed care. The members of this project group were to take part in site visits to the 27 HRSA grantees, assist in providing initial on site technical assistance, document the site visits, and participate in analyzing the project=s overall findings and recommendations.

The project, as proposed to HRSA and executed in this effort, delineated initially a set of seven factors to be used in examining third-party reimbursement within the operational contexts of the 27 grantee organizations:

- $ Third-party (Medicaid/Medicare) provider status of the grantee
- $ Eligibility of the grantee=s patient base for third-party program coverage
- $ Medicaid/Medicare coverage of services provided by the grantee
- $ Rate of payment from third parties compared with costs to the grantee
- $ Adequacy of the grantee billing system to maximize reimbursement
- $ Impact of mandatory managed care on grantee revenue
- $ Overarching issues

The initial six factors formed the basis for the development of a uniform data-gathering protocol to be used in making site visits to the grantees. Ultimately, a seventh factor, Aoverarching issues,@ was added as a factor analysis because the identification of barriers from the field experience included overarching problems that did not fall rationally and uniquely within any of the original six factors.

Between November of 1999 and March of 2000, visits were made to the 27 designated grantee organizations by project teams of two to four individuals. In the interest of consistency and continuity, either the Project Director or the Deputy Director served as team leader for all of the site visits.

Over the course of the two- to three-day visits, the teams followed the original seven-point protocol in reviewing relevant documents and records, observing processes, and conducting open-ended individual and small-group interviews on programmatic and financial matters pertaining to third-party reimbursement. In order to gain a comprehensive understanding of how HRSA grant program activities and funding fit into and were affected by the overall structure and operations of the grantee organizations, discussions were held with the organizations= administrative and fiscal personnel (to the extent of availability during the site visit), as well as with the program staff directly involved in the management and performance of grant-funded activities. In addition, under the HRSA contractual expectations and at the request of site personnel and to the degree that time permitted, the project teams provided technical assistance generally on strategies that the grantee organizations might adopt to enhance third-party reimbursement.

Following each site visit, the team members concerned prepared a report that included preliminary findings and organization and program-specific recommendations on strategies for enhancing third-party revenue. Copies of these site visit reports were then distributed to the 27 grantee entities and to the HRSA Steering Committee for review and comment.

Once all of the 27 designated organizations had been visited and the site visit reports had been completed and distributed, the project group conducted the seven-point analysis of the overall findings on third-party reimbursement. The findings/barriers were classified by type of grantee, by 18 clusters of problem types (designed to further focus on the problems) under each of these seven factors (see delineation below), and by whether the problem was in the control of the grantee (in control), out of grantee control (out of control) or ultimately out of grantee control but under its influence (both). Additionally, to the extent that data were available, each of the problem areas was quantified according to the level of third-party reimbursement revenue that might be realized if the problems/barriers were resolved.

This reimbursement analysis was then presented to the HRSA Steering Committee at its monthly meeting of July 2000. The interpretation of findings chapter of the report is presented in the context of the seven-factor analysis and includes delineation of the findings by grantee type and by whether the finding is in or out of grantee control or both.

It is important to note that in the conceptualization and early execution of this project, some HRSA programs and constituencies were inadventerly omitted: school-based clinics, freestanding migrant health centers, and Asian and Pacific Islanders. They should be included in further efforts of this nature, and resulting recommendations should be tailored to meet their unique needs.

3. SEVEN-FACTOR ANALYSIS WITH PROBLEM AREAS

Exhibit ES-1 identifies the seven factors used to conduct the analysis and the specific problem areas that related to each of the factors.

4. RESULTS

Results are summarized here by the seven factors in the analysis, with the detailed analysis found in Chapter II and the summary of the findings, along with the team=s considerations, in Chapter III. No single factor or problem acted exclusively as a reimbursement problem/barrier; multiple problems drove the barriers to grantee third-party reimbursement. Chapter IV addresses the conclusions and recommendations.

Exhibit ES-2 presents the results of the analysis and the frequency of site visit findings by problem area.

4.1 Provider Status

The third-party provider status of the grantee was a significant factor driving third-party reimbursement potential. Some third-party provider designations, such as rural health center (RHC), Federally Qualified Health Center (FQHC), hospital outpatient department (OPD), etc., present greater Medicare/Medicaid reimbursement opportunities than others, such as physician fee-for-service billing. Barriers to reimbursement in this area include State licensing restrictions, grantee failure to recognize third-party provider designation opportunities, especially FQHC status, and insufficient grantee data and accounting systems to fully participate in these opportunities. Some of these barriers were internal to the grantee and resolvable with training and technical assistance efforts; other barriers were a problem of State and/or Federal policy clarification or incongruence that would require State-based strategies or policymaker

reconsideration. Provider status problems were found at 12 of the 27 sites.

4.2 Eligibility

Eligibility for third-party coverage was a factor identified at most of the sites. Problem areas such as inadequate assistance in enrollment by the grantee, patient eligibility barriers, and grantee lack of recognition of eligibility windows surfaced under this factor analysis. Inadequate assistance in enrollment included the lack of State implementation of Medicaid outstationed eligibility workers (a 10-year-old Federal requirement that most States have not implemented), lack of eligibility procedural coordination at the State and local levels, and minimum understanding of the dual eligibility (Medicare/Medicaid), QMB, and SLMB programs and eligibility procedures.

Patient eligibility barriers included the 24-month Medicare waiting period for Social Security Disability Income beneficiaries, the eligibility limitations for undocumented residents, and the cumbersome State eligibility procedures and requirements that act as a barrier for all applicants, especially special populations, such as homeless, immigrants, and non-English speaking. Underutilization of eligibility windows occurred when the grantee did not bill for services provided during the period after eligibility determination and before managed care enrollment, when the State provided for such an opportunity. Eligibility-related problems were found at 19 of the 27 sites studied.

4.3 Covered Services

Four distinct problem areas emanated from the covered services factor analysis: lack of grantee staff certification, deficient waiver and case management coverage, services not reimbursed by the third-party payors, and nonreimbursable staff. Lack of grantee staff certification emerged largely in the area of case management staff certification, required in two of the three States studied. Deficient waiver and case management coverage included services that States did not include in their Medicaid plans, such as case management for certain target groups (e.g., HIV/AIDS patients), waiver services to high-risk pregnant women and children, and required screening and case management services to children with an elevated blood lead level. Services not reimbursed by third-party payors include services for tuberculosis (TB) services, where the patient is Medicaid eligible simply by virtue of having TB, and some immunizations, due to confusion over and disincentives to billing for these services. In the nonreimbursable staff problem area, required Medicare/Medicaid Aincident to@ compliance was not operational and grantee staffing patterns (e,g. family practice MDs and nurse practitioners) were not always recognized by managed care organizations (MCOs)/payors. Problems in covered services were found at 22 of the 27 sites, largely in the case management covered services area.

4.4 Rates and Costs

Analyzing the difference between the grantee=s cost of providing services and the third party=s rate of reimbursement for such services revealed three problem areas, which together represent one of the most frequent (21 of the 27 sites studied) and given the limitations of available data, the single most costly element (over half of the total lost dollars identified in this effort). These three problem areas are deficient rates, i.e., rates of reimbursement do not reflect the cost of care; inadequate cost and charge setting, i.e., costs are not

in line with charges; and deficient FQHC/RHC wraparound payments, i.e., full reasonable-cost payment protections in mandatory Medicaid managed care are not guaranteed by Federal statute over time. Rates and costs factor problems were found at 21 of the 27 sites.

4.5 Billing Systems

Billing systems was one of the most pervasive factors, with its three problem areas, encountered during these site visits (23 of the 27 sites had problems in this area). While the dollar impact of revenue lost may be low, estimates were difficult for the same reason that the problems arose (i.e., inadequate recordkeeping). The team determined that this is one of the most easily correctable difficulties with the appropriate type and intensity of training and technical assistance. The three problem areas identified were inadequate billing, lack of billing at all, and inadequate accounting and record keeping. These problems largely stem from grantees or their local leadership not seeing the value of billing and/or insufficient systems to generate and document billings and collect third- party reimbursement. Billing systems factor problems were found at 23 of the 27 sites visited.

4.6 Managed Care Impact

The major problem identified in this managed care impact analysis was that there was a clear deficiency in managed care contracting between the State and the MCOs and between the MCOs and the grantees. MCOs, often backed by the State, established difficult credentialing requirements, never engaged in serious contract negotiations with the grantee and, in general, were not interested in contracting with grantees at all. Confusing State definitions of covered/in-plan services and insufficiently established capitation rates further complicates the problem and provides for disincentives for MCOs to contract with grantees. Managed care impact factor problems were found at 18 of the 27 sites studied. Dollar estimates were low given the difficulty in securing data and that not all grantees studied are presently in mandatory Medicaid managed care environments.

4.7 Overarching Issues

The seventh factor, overarching issues, was added after the study began in order to capture those problems/barriers that did not fit uniquely under the original six factors. The three problem areas emerging from this factor analysis were: unfavorable policies, regulations, and legislation; Medicaid State matching issues; and Disproportionate Share Hospital (DSH) payments.

Unfavorable policies, regulations, and legislation encompasses a variety of State and Federal policies that have an inadvertent negative impact on grantee third-party reimbursement, such as homeless, migrant, and HIV/AIDS patient eligibility and covered services barriers, the higher cost of care for special populations not being reflected in third-party payor rate setting, third-party payment limitations on the grantee/provider location of the service (e.g., FQHC physicians following their patients when hospitalized and hospitals setting up outreach outpatient sites as increased patient access points), insufficient third- party late payment policies or compliance, insufficient third-party late payment policy or compliance, insufficient presumptive eligibility implementation and newborn eligibility determination, and confusion over the policy regarding Afirst or last dollar@ payment by Medicaid or grant dollars.

Medicaid State matching problems include State Medicaid matching strategies whereby the State uses local dollars to match Federal Medicaid dollars but does not return its proportionate total Medicaid spending to the local level, resulting in a diminishment of services to patients locally. States appear not to be fully taking advantage of Medicaid Federal matching opportunities for increased service delivery, such as administrative case management, 1915(c) waivers, and Aovermatching@ block grants (e.g., MCH and Ryan White Title II) instead of using the Aovermatch@ for Medicaid to leverage more service dollars.

DSH payments have become a problem for grantees designated as DSHs. This emanates from the tactics used by States to generate Federal DSH payments and to distribute these payments to hospitals within the Sate and the consequent restrictions/cutbacks Congress has imposed in recent years on DSH payments. The result is that grantee programs housed within grantee organizations that are DSHs are suffering the loss of resources for uninsured patients, who are represented in large numbers among the grantee programs. Nine of the 27 grantees were identified as DSH hospitals.

Overarching issues-related problems were found at 20 of the 27 sites.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

A major conclusion of this project is that to a considerable extent, HRSA grantee organizations absorb the costs of providing health care services to poor people rather than being reimbursed by third-party entitlement programs such as Medicare and Medicaid. In effect, health care costs for the covered patients are being shifted from entitlement programs to HRSA grants. Moreover, although Federal policy initiatives have attempted to clarify which government entities under which circumstances should pay Athe first and last dollar,@ the project team found considerable confusion within HRSA and among the three States and the 27 grantee organizations included in this assessment in regard to first dollar/last dollar responsibility.

As an example, the project team found that this Acost shifting@ phenomenon is fostered at the Federal level by the statutory language that patients with Social Security Disability Insurance (SSDI) status must undergo a two-year waiting period to attain Medicare eligibility (except for those with end-stage renal disease). Thus, some other source is required to support the cost of their health care in the interim. In the case of uninsured HIV/AIDS patients, for example, health services are subsidized by Ryan White grant dollars for a two-year period rather than reimbursed by Medicare**C**even though the patients have already been determined to be disabled by the Social Security Administration and are receiving SSDI monthly income assistance checks.

At the State level, the team noted that cost shifting occurs in various ways. The State governments tend to view HRSA grantees such as FQHCs and RHCs as manifestations of Federal programs and requirements for which States should not have to take primary responsibility for cost. The States are therefore resistant to paying for care provided to their Medicaid patients by FQHCs and RHCs in accordance with reasonable cost reimbursement. Further, the States= approach to Medicaid Disproportionate Share Hospital

payments is to maximize the Federal DSH drawdown without assuming concurrent responsibility for ensuring that patient care is maximized with DSH dollars.

To counter this cost-shifting tendency, a DHHS clarification and dissemination of a Alast dollar@ policy would be needed. Such a Federal policy statement would be strengthened by HRSA=s development and execution of a strategy for its grantees to enhance third-party reimbursement. This would entail using something like the Atotal budget@ concept that the Bureau of Primary Health Care employs to determine levels of grant funding to CMHCs. In this approach, grantees develop expense budgets and then project the third-party revenue that will be applied to these expenses. The level of BPHC grant funding is then determined by reviewing the expense budgets (including the projected third-party revenue) and applying BPHC funding criteria. The BPHC funding procedure underscores the notion of third-party reimbursement as Afirst dollar@ in the CMHC grant program budgeting process in a way that may well represent a viable model for HRSA grant programs as a whole.

Much confusion and many difficulties were found to result from terminological differences in the health care arena. Public Health Service language is not necessarily congruent with Medicare/Medicaid third-party reimbursement nomenclature. For example, are MCH Ahome visiting services@ really the same thing as Medicaid Acase management services@? Definitional differences between HRSA and HCFA concerning covered services, especially in regard to case management services, currently cause considerable third-party reimbursement to be lost to HRSA grantees. Contracting issues between State Medicaid programs and managed care plans have further complicated matters, because these two entities use the same terms to express different concepts. Hence, Medicaid might define case management as a facilitating or Adoor opening@ service, whereas a managed care organization might define case management as a utilization control or a Adoor closing@ function. States generate additional terminological problems by adopting local marketing jargon, such as in Pennsylvania=s Healthy Beginnings and Healthy Beginnings Plus programs, which may change from time to time, from one administration to another, or from one stage of Medicaid managed care to another. This phenomenon causes considerable confusion for patients and community providers, and in Pennsylvania and Texas it has even led to lawsuits seeking clarification of coverage.

The project team also concluded that significant barriers to enhancing HRSA grantee third-party payment lie in the variation and complexity of State Medicaid and CHIP programs. Relevant factors include:

- **$** Variations among States in policy and budgetary dynamics driven by differences in State executive and legislative parameters

- **$** Variation from State to State in matching Federal dollars in Medicaid, which may reflect a greater concern with State cost containment than with the provision of more health care to more persons

- **$** Differences in State Medicaid/CHIP plans and stage of CHIP implementation, eligibility criteria and requirements, and covered services, payment provisions, and procedural requirements

- Differences in State Aamount, scope and duration@ policy requirements allowed under Federal statute and executed differently State by State

- Differences in State managed care developments and stages of execution, which have varying impacts on HRSA grantees

Therefore, HRSA grantee strategies and solutions need to effectively address State-specific health care environments and dynamics.

The project team reached a number of conclusions in regard to how the HRSA grantees are faring in a rapidly changing health finance environment:

- FQHC/RHC wraparound payments to cost set forth in the Federal statute presently protect FQHC/RHC payments, but the future is unclear; State-based implementation of Federal protections has been contentious and has resulted in some grantees experiencing shortfalls in spite of Federal statutory protections.

- DSH payments are being greatly reduced, diminishing DSH provider entities: capacity to provide care to uninsured patients. HRSA grant programs and grantees in the main do not understand DSH payment policies or know how to navigate strategically to secure the benefits of these payments for their patients.

- For the most part, HRSA granteesCFQHCs and hospitals exceptedCdo not view third-party reimbursement as a priority and do not indicate that they have a clear sense of direction from HRSA on the value of securing third-party reimbursement for services. This lack of a sense of high priority and direction has in some cases resulted in little or no billing, accounting, and recordkeeping infrastructure.

- A lack of understanding of managed care contracting represents the major Medicaid managed care difficulty for HRSA grantees. Some simply do not understand the implications and parameters of a managed care environment, and grantee impacts include being unable to contract with managed care plans in the face of plan resistance and grantee lack of leverage in contract negotiations.

- Grantee billing systems vary widely in degree of sophistication and adequacy, yet third-party payor systems have become increasingly complicated and diversified, especially with Medicaid managed care developments. Grantees thus have difficulty in responding to third-party payor requirements in an efficient and effective manner without making a major investment in billing infrastructure designed to deal with third-party reimbursement. In addition, Medicaid Presumptive Eligibility opportunities are not being fully utilized by all grantees.

- Third-party payors, in setting payment rates, do not commonly take into account the greater costs entailed in providing care to the vulnerable populations served by HRSA

grantee organizations in terms of either patient mix or service mix, nor do they utilize such appropriate health financing mechanisms as risk adjustment to accommodate patient and service mix.

Finally, on the basis of their broad experience, the project team concluded that the circumstances in which the HRSA grantees find themselves and the barriers that they face are hardly restricted to the three States included in the assessment. Rather, the nature and extent of the problems encountered may be readily found all around the country. Therefore, in all 50 States, skill and flexibility will be essential for developing strategies and executing solutions that will achieve success in enhancing third-party reimbursement for all HRSA grantees—and thus make scarce grant dollars available to serve a greater number of vulnerable uninsured and underinsured persons throughout the nation.

5.2 Recommendations

Recommendations for enhancing third-party reimbursement fall into three major categories: training and technical assistance, State-based strategies, and policy considerations. Specific recommendations are presented for training grantees and others in national-level conference sessions and in State-level meetings, both directly and through the use of videos. Technical assistance is suggested for grantees, both individually and in small clusters. Recommendations are given for developing and implementing State-based strategies that reflect the uniqueness of each State=s environment, the nature and extent of the problem being addressed, whether the problem can be resolved at the State level, the knowledge and sophistication of the State=s grantees, the viability of collective action, and the infrastructure within the State to support the effort. The recommendations on policy considerations are occasionally internal to HRSA, but more often, given the nature of third-party reimbursement, require collaboration between HRSA and HCFA and may also require legislation. Detailed recommendations for each of these three areas are found in Chapter IV of the report.

The following suggestions are offered as potentially useful ways to operationalize these recommendations:

- HRSA should consider developing a national training center to house all of the third-party reimbursement training and TA activities that it decides to implement. Such a center could gather and maintain the talent and information necessary for conducting an important endeavor of this magnitude.

- HRSA should develop some in-house capacity regarding third-party reimbursement that would have the responsibility of third-party issue identification and policy analysis, HCFA liaison activity, support for Bureaus and grantees, research and development (e.g. risk-adjusted payments) and providing priorities and direction for the training center.

- Videos and video conferencing should be developed for training to the extent that it is cost-effective and the technology is accessible for the grantees.

- The development and implementation of the training, TA, and State-based strategies should be carried out collaboratively with the national and State associations representing HRSA grantees (such as the National Association of Community Heath Centers, the Association

of Maternal and Child Health Programs, the National Council for the Homeless, and the many State primary care and rural health associations), as well as with State Health Departments and State Medicaid Agencies, as appropriate.

- $ Given the nature of much of the training and TA to be conducted, consideration should always be given to providing assistance through State-based delivery models, especially since State Medicaid and State Children=s Health Insurance Programs can vary widely and have a significant third-party impact on HRSA grantees.

- $ In light of the generally well developed organizational structures and functions of State primary care associations and State rural health associations, HRSA should give consideration to the potential for these State associations to represent all HRSA grantees or for HRSA grantees to form State associations by grantee type and then coalesce, as associations, around common issues. Factors that should be weighed would be: cost-effectiveness, infrastructural viability, strategic advantages, and comparison with other options for carrying out the collaborative, concerted action that will be required at the State level.

- $ HRSA should seek a collaborative working task force with HCFA to address the recommendations/resolutions in this report.

- $ HRSA should initiate an assessment of the nature and extent of HCFA=s willingness to collaborate in the training and TA, State-based strategies, and policy development activities recommended in this report. In fact, HCFA collaboration may very well be essential for the successful achievement of many of the recommendations.

- $ HRSA should seek to clarify the HHS policy regarding Afirst dollar/last dollar@ responsibility between HRSA=s grant programs and HCFA=s entitlement programs in order to maximize the use of HRSA grant dollars for uninsured patients and services not covered by third-party reimbursement, as appears to have been the original intent of congressional legislation and HHS policy. This HHS policy clarification should be transmitted to State governments and grantees to ensure that there is adequate and appropriate implementation of Federal policy in this regard.

- $ Given that HRSA often provides grants to large institutional grantees and that third-party revenue generated by the grantee may not be targeted for the grantee program that generated the revenue, HRSA should consider requiring that the third-party revenue generated by the grantee program be returned to the program, specifically as a grant condition that HRSA monitors for compliance.

- $ HRSA should launch a HRSA-wide research and development effort around its third-party risk-adjusted payment methodology for targeted populations (e.g., HIV/AIDS Bureau efforts for HIV/AIDS patients). This effort might be explored collaboratively with AHRQ, which has expressed some interest in this area.

- HRSA should establish a minimum third-party reimbursement data set for all its grantees in order to monitor the effectiveness of its third-party enhancement initiatives and also to assess trends in third-party reimbursement and their impact on grantees at the local level over time.

- It would be helpful for HRSA=s individual Bureaus to share relevant information on their respective policies, procedures, and initiatives regarding third-party reimbursement with one another. Two cases in point are the Bureau of Primary Health Care=s Atotal budget@ grant allocation procedures and the HIV/AIDS Bureau=s exploration of Arisk adjustment@ factors in managed care rate setting.

- Given the tensions that often emerge in State/local interaction concerning Medicaid local matching dollars, HRSA should identify State Abest practices@ that create congruent incentives for State and local entities and share these best practices across the country.

Chapter IV of the report details the recommendations further and should be reviewed to determine specific strategies and direction.

EXHIBIT I-1

SEVEN-FACTOR ANALYSIS WITH PROBLEM AREAS

Factor 1:	**Third Party Provider Status**	
	Problem 1:	Third party provider designation
Factor 2:	**Patient Eligibility**	
	Problem 2:	Inadequate assistance in enrollment
	Problem 3:	Eligibility barrier
	Problem 4:	Failure to recognize Medicaid managed care eligibility enrollment window
Factor 3:	**Covered Services**	
	Problem 5:	Lack of staff certification
	Problem 6:	Deficient waiver and case management coverage
	Problem 7:	Services not reimbursed
	Problem 8:	Nonreimbursable staff
Factor 4:	**Rates and Costs**	
	Problem 9:	Deficient rates
	Problem 10:	Inadequate cost and charge setting
	Problem 11:	Deficient Federally Qualified Health Center and Rural Health Clinic wraparound payments
Factor 5:	**Billing Systems**	
	Problem 12:	Inadequate billing
	Problem 13:	Lack of billing
	Problem 14:	Inadequate accounting and recordkeeping
Factor 6:	**Managed Care Impact**	
	Problem 15:	Deficient managed care contracting
Factor 7:	**Overarching Issues**	
	Problem 16:	Unfavorable policy, regulation, legislation
	Problem 17:	Lack of Medicaid administrative matching
	Problem 18:	Desproportionate Share Hospital reimbursement

EXHIBIT ES- 2

FREQUENCY OF SITE VISIT FINDINGS
BY PROBLEM AREA

Factor/Problem Area	Number of Sites Out of 27 Studied Where the Problem Occurred
Provider status/third-party provider designation	12
Eligibility barriers	19
Inadequate assistance in enrollment	8
Patient eligibility barriers	16
Not recognizing eligibility window	2
Covered services:	22
Lack of staff certification	7
Deficient waiver and case management coverage	22
Services not reimbursed	7
Non reimbursable staff	6
Rates and costs:	21
Deficient rates	8
Inadequate costs and charge setting	15
Deficient FQHC/RHC around wrap	4
Billing systems:	23
Inadequate billing	17
Lack of billing	5
Inadequate accounting and record keeping	18
Managed care impact/deficient managed care contracting	18
Overarching issues:	20
Unfavorable policy, regulation, and legislation	15
State matching issues	9
DSH problems	9